

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 013330	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/24/2014
NAME OF PROVIDER OR SUPPLIER HERITAGE POINT ALZHEIMER'S SPECIAL CARE CEN		STREET ADDRESS, CITY, STATE, ZIP CODE 1215 TRINITY PLACE MISHAWAKA, IN 46545		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Compliant IN00159737.</p> <p>Complaint IN00159737 - Unsubstantiated, due to lack of evidence.</p> <p>Survey Dates: November 24, 2014, 2014.</p> <p>Facility number: 013330 Provider Number: N/A AIM Number: N/A</p> <p>Survey team: Diana McDonald, RN-TC</p> <p>Census bed type: Residential: 10 Total: 10</p> <p>Census payor type: Other: 10 Total: 10</p> <p>Heritage Point Alzheimer's Special Care Center was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00159737.</p> <p>Quality Review 11/25/14 by Lisa McColly</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE